DELTA DENTAL®
Northeast Delta Dental

DELTA DENTAL PLAN OF MAINE
DELTA DENTAL PLAN OF NEW HAMPSHIRE
DELTA DENTAL PLAN OF VERMONT

NORTHEAST DELTA DENTAL
One Delta Drive
PO Box 2002
Concord, New Hampshire 03302-2002
(603) 223-1000 Corporate
(603) 223-1230 Eligibility
(603) 223-1252 Eligibility Fax

PLEASE PRINT OR TYPE - IN BLUE OR BLACK INK ONLY.

❶ EMPLOYEE INFORMATION

LAST NAME |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| (17 CHARACTERS ONLY) FIRST NAME |__|__|__|__|__|__|__|__| (8 CHARACTERS ONLY) BIRTHDATE |__|__|__|__|__|__| MO DAY YEAR

SOCIAL SECURITY # |__|__|__|-|__|__|-|__|__|__|__| **SEX** ☐ M ☐ F

MARITAL STATUS SINGLE ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ WIDOWED ☐

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE # ( ) _____ DATE OF HIRE _____ DATE OF REHIRE _____

EMPLOYER NAME _____ ADDRESS _____

GROUP NUMBER _____ **SUBLOCATION NUMBER** _____ **EFFECTIVE DATE** _____

❷ REASON FOR APPLICATION (CHECK APPROPRIATE BOXES) ☐ ADD ☐ DELETE

- ☐ NEW
- ☐ ANNUAL OPEN ENROLLMENT
- ☐ CHANGE OF NAME/ADDRESS
- ☐ CHANGE OF STATUS

EXACT DATE OF EVENT: _____

CHANGE IN STATUS DUE TO:

- ☐ MARRIAGE
- ☐ BIRTH
- ☐ ADOPTION
- ☐ SPOUSE'S EMPLOYMENT CHANGE
- ☐ NO LONGER DEPENDENT FOR IRS PURPOSES
- ☐ RETIREMENT
- ☐ DIVORCE
- ☐ LEGAL SEPARATION
- ☐ DEATH
- ☐ OTHER _____

NOTE: IF ENROLLING ONE ELIGIBLE DEPENDENT, ALL MUST BE ENROLLED. IF ENROLLING DEPENDENT CHILDREN OVER 19 PLEASE INDICATE NEXT TO NAME IF DEPENDENT IS A STUDENT OR INCAPACITATED.

❸ DEPENDENT INFORMATION NOTE: LIST ONLY DEPENDENTS FOR WHOM CHANGE OF STATUS IS REQUESTED

LAST NAME	FIRST	INITIAL	SEX	BIRTH DATE	RELATIONSHIP

❹ TYPE OF COVERAGE (PLEASE CHECK ONE)

- ☐ 1 - EMPLOYEE ONLY
- ☐ 2 - EMPLOYEE & SPOUSE
- ☐ 3 - EMPLOYEE, SPOUSE & CHILDREN
- ☐ 5 - EMPLOYEE & CHILD
- ☐ 6 - EMPLOYEE & CHILDREN

❺ PREVIOUS/EXISTING COVERAGE

WILL THIS DENTAL COVERAGE REPLACE ANOTHER NORTHEAST DELTA DENTAL PLAN? ☐ YES ☐ NO

IF YES, GROUP NO. _____ SOCIAL SECURITY NO. OF PERSON COVERED _____

WILL YOU OR ANY OF YOUR FAMILY MEMBERS HAVE DENTAL COVERAGE FROM ANOTHER DENTAL PLAN? ☐ YES ☐ NO

IF YES, NAME OF THE INSURER _____ POLICY NO. _____

EFFECTIVE DATE OF PLAN _____ ☐ SINGLE ☐ TWO PERSON ☐ FAMILY

THIS INFORMATION IS REQUIRED SO THAT DELTA MAY COORDINATE BENEFITS WITH THE OTHER CARRIER SO THAT YOU MAY BENEFIT FROM DUAL COVERAGE.

❻ I CERTIFY THAT ALL INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. ALSO, I UNDERSTAND THAT THE EFFECTIVE DATE AND TERMINATION DATE OF MY MEMBERSHIP WILL BE DETERMINED BY MY EMPLOYER OR PLAN SPONSOR IN ACCORDANCE WITH THE UNDERWRITING GUIDELINES OF NORTHEAST DELTA DENTAL. IF MY EMPLOYER OR PLAN SPONSOR REQUIRES EMPLOYEE CONTRIBUTIONS FOR THIS COVERAGE I AUTHORIZE THE DEDUCTIONS OF THESE AMOUNTS FROM MY WAGES. I UNDERSTAND THAT MY DEPENDENTS MUST REMAIN ENROLLED AND BE DROPPED ONLY DURING CONTRACT REOPENING, EXCEPT IN THE EVENT OF FAMILY STATUS CHANGE.

SIGNATURE _____ DATE _____

Please keep a copy for your records